

Sample Adult Benefit Plans from Three States

	Service	Benefit limitations		
Service category		Pennsylvania Limited	New Mexico Medium	New York Comprehensive
Diagnostic and preventive	Periodic exam	One per 180 days	Not covered	One per six months
	Comprehensive exam	One per lifetime, per provider/location	One per 12 months	One per lifetime, per provider/location
	Prophy	One per 180 days	One per 12 months	One per six months
	Fluoride	Not covered	One per 12 months	One per six months. Only in cases where salivary gland function has been compromised through surgery or radiation.
	Bitewings	Covered	Covered	One per six months
	Full mouth series	One per 60 months	One per 60 months	One per 36 months, per provider/location
Restorative	Fillings (amalgam and composite)	One per tooth, per surface, per 36 months	One per tooth, per surface, per 36 months	One per tooth, per surface, per 12 months
	Resin and porcelain crowns	Not covered	Not covered	Crowns will not be routinely approved for a molar tooth in those beneficiaries age 21 and over which has been endodontically treated without prior approval from the Department of Health.
	Stainless steel crown	Not covered	One per tooth, per 36 months	One per tooth, per 24 months
	Prefabricated crowns	Not covered	Not covered	One per tooth, per 60 months
Endodontics	Pulpotomy	Covered	Not covered	Not covered
	Root canal	Not covered	One per tooth, per lifetime. For anterior teeth only.	Anterior, bicuspid and posterior covered. One per tooth, per lifetime.
	Retreatment of root canal	Not covered	Not covered	One per tooth, per lifetime
	Apicoectomy/periradicular surgery	Not covered	Not covered	One per tooth, per lifetime
Periodontics	Gingivectomy or gingivolpasty	Not covered	One per 36 months, per quadrant	One per 24 months, per quadrant
	Scaling and root planning	Not covered	Minimum four teeth in affected quadrant. One per 24 months per quadrant.	One per 34 months per quadrant (1-3 teeth or 4 or more)

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Service category		Pennsylvania Limited	New Mexico Medium	New York Comprehensive
Prosthodontics	Complete denture	One per lifetime	One per 60 months	One per 96 months
	Partial denture	One per lifetime	One per 60 months	One per 96 months
	Reline	One per 24 months	One per 36 months, not covered within six months of placement	One per 12 months. Not covered within six months of placement.
Oral surgery	Simple extractions	Removal of asymptomatic tooth not covered	Removal of asymptomatic tooth not covered	Removal of asymptomatic tooth not covered
	Surgical extractions	Removal of asymptomatic tooth not covered	Removal of asymptomatic tooth not covered	Removal of asymptomatic tooth not covered
	Removal of cysts and tumors	Covered	Covered	Covered
Adjunctive general services	Palliative treatment	Not allowed with any other services other than radiographs and behavior management.	Not allowed with any other services other than radiographs.	Not allowed with any other services other than radiographs.
	General anesthesia	Covered	Covered	Provider needs to have appropriate level of certification in dental anesthesia
	IV sedation	Covered	Four units per date of service, not timed	Provider needs to have appropriate level of certification in dental anesthesia
	Behavior management	One per day. Four per calendar year.	Not covered	For developmentally disabled population